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ABSTRACT

This paper provides an overview of how Massachusetts has successfully integrated use of the federal Medicaid program into a plan for financing Part H of Public Law 99-457, the 1986 Amendments to the Education of the Handicapped Act, on a statewide basis. Noted is the lack of a single strategy for accessing Medicaid funds for early intervention services. In the first section the legislative authority to finance early intervention services with Medicaid funds is briefly reviewed. The next section looks at barriers and benefits to this type of financing, administrative considerations, and defining early intervention services in the Medicaid State Plan. Issues regarding implementation of Medicaid support are considered next and include responsibility for early intervention program development, defining units of early intervention services and unit rates, costs of a Medicaid plan, and planning for change. Noted are the issues of availability of state matching funds, the need for initiative by Part H Lead Agency Administrators, the existence of barriers related to issues of values and language, and the importance of defining early intervention services with precision utilizing a unit rate purchasing system. (DB)

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THE MASSACHUSETTS EXPERIENCE
WITH MEDICAID SUPPORT OF
EARLY INTERVENTION SERVICES

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FOREWORD

This contribution to the Carolina Policy Studies Program (CPSP) series of reports on the implementation of Part H of P.L. 99-457 is comprised of three independent papers on financing services. These papers are aimed primarily at state level administrators and are intended to present public policy perspectives on the complex task of financing services for infants and toddlers with handicaps and their families. The papers were originally prepared for a small policy conference held in Chapel Hill, N.C., to explore major financing issues to guide our future work on implementation of the law, and have since been substantially revised and updated for this report.

This paper, **The Massachusetts Experience with Medicaid Support of Early Intervention Services**, was written by Karl Kastorf, Part H Coordinator in Massachusetts. As indicated by the title, the paper provides an overview of how one state has successfully integrated use of the federal Medicaid program into a plan for financing Part H services on a statewide basis. Many states have found it difficult to maximize use of this potentially large and important source of federal and state financial support for Part H services. It is hoped that the Massachusetts experience will be helpful to other states as they develop and refine their own strategies.

The second paper, **State Financing of Services Under P.L. 99-457, Part H**, was written by Richard Clifford, Associate Director of CPSP, and is the initial report of the CPSP case study of six states' efforts to implement the financial provisions of the law. It describes the sources and funding mechanisms used in the six states, and makes recommendations regarding state response to the requirements of Part H. It should be noted that the other two papers were prepared because of the authors' extensive experience in particular aspects of financing services, and are not related to the case studies reported in the **State Financing** paper.

The third paper, **Use of Parental Fees for P.L. 99-457, Part H**, was prepared by Peter Van Dyck, M.D., M.P.H., Director of the Division of Family Health Services for the Utah Department of Health. He has had extensive experience in addressing issues related to financing services. This paper focuses primarily on use of parental fees as a source of funding for Part H services. It is impossible to completely separate parental payment for services from the use of private insurance. This paper provides meaningful insights into this important topic.

We greatly appreciate the time and expertise shared with us by the many participating staff members in the six case study states. Their willingness to spend substantial amounts of time with us, both personally and in gathering reports, memoranda and other documents to enable us to conduct the case studies, has been invaluable. We have come to respect them for their work on a tremendously difficult task. As you will see from the Clifford paper, we have questions about the possibility of truly fulfilling the intent of the financing provisions of the law. If it is possible, it will only be because of the dedicated work of the Part H Coordinators and their colleagues across the country.

This is the first time the Carolina Policy Studies Program has relied on state personnel to independently prepare policy papers for this series. Special appreciation is due to Karl Kastorf for his excellent work in describing Massachusetts' pioneering efforts at maximizing the use of Medicaid as a major source of financial support for Part H services. Kathleen Bernier, a colleague here at CPSP, had major responsibility for editing this paper for inclusion in this series and her work is greatly appreciated.

Richard M. Clifford
March, 1991

In late 1983, prior to the passage of the Handicapped Infants and Toddlers Program of the Individuals with Disabilities Education Act (formerly the Education of the Handicapped Act), P.L. 99-457, Part H, the Massachusetts legislature enacted legislation that designated the Department of Public Health (DPH) as the Lead Agency for early intervention (EI) services. The state legislation also mandated Medicaid participation in the financial support of those services. In the opinion of administrators in Massachusetts, this statute has had direct benefits for children and families in Massachusetts. By 1989, the total state and federal Medicaid expenditures for EI services was about \$3.4 million, slightly more than 25% of all state and federal funds expended for these services in Massachusetts, and the numbers of children receiving EI services supported by Medicaid and other state and federal sources had almost tripled.

This paper is intended to describe the experience of Massachusetts administrators with the implementation of the Medicaid funding of early intervention. Massachusetts seems to be unique both in the manner and the extent of Medicaid utilization for these services. There continues to be national interest in what has been done, and Massachusetts administrators have had the opportunity to respond to questions from many other states. In part, the organization of this paper and the areas detailed are an effort to respond to the themes that have emerged from these questions.

There is not, and cannot be, one single strategy or set of well defined tasks to follow in order to access Medicaid funds for early intervention services. Political and economic conditions

vary from state to state. These conditions shape the attitudes and experiences of state legislators and administrators regarding state/federal relationships. Title XIX of the Social Security Act, the federal mandate that created Medicaid, both requires states to offer certain services and presents states with the opportunity to provide additional services, with federal financial participation. More than anything else, the attitude of the state's body politic on requirement vs. opportunity will shape state participation in this program.

LEGISLATIVE AUTHORITY TO FINANCE EARLY INTERVENTION SERVICES WITH MEDICAID FUNDS

The authority of states to use Medicaid funds for the provision of early intervention has been well established by federal legislation, regulation, and court decisions. Part H of P.L. 99-457 specifically permits such use of Medicaid funds. In *Bowen v. Massachusetts* (U.S. Supreme Court, 87-712 and 87-929), the Supreme Court ruled that the federal administration could not enforce a regulation that prohibited the use of Medicaid funds for services listed in an Individual Education Plan. In the Omnibus Budget Reconciliation Act of 1988 (OBRA '88), Congress adopted this opinion as statute. In general, Congress has expressed an increasingly liberal attitude toward the use of Medicaid funds for services to disadvantaged mothers and young children. The changes made in OBRA '89 to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program seem to confirm the intent of Congress to provide a very broad range of treatment services to children.

Regardless of this permissive context, there is no federal language in statute or regulation requiring states to use Medicaid funds specifically for EI services. States must choose to do so and must design and implement specific strategies for doing so. Federal law does not require state legislative action to access Medicaid funds for EI services, although some state legislatures have required legislative approval for any changes in the Medicaid State Plan. When legislative action occurs, implementation of a plan to access Medicaid funds for EI services is facilitated. If accompanied by an appropriation, such action paves the way for service initiation or expansion.

INITIAL CONSIDERATIONS IN FINANCING EARLY INTERVENTION SERVICES WITH MEDICAID FUNDS

Benefits and Barriers

All Medicaid expenditures are shared by the state and federal government. The percentage of Federal Financial Participation (FFP) varies by state and type of service (e.g., case management and administration of certain federal requirements are reimbursed at a higher federal percentage). In practical terms, this means that states wishing to initiate new services, such as early intervention, must appropriate state funds to do so. Once such an appropriation is made, FFP will begin reimbursements to the state. The state may not, however, plan to reduce its expenditures in subsequent years and rely on the FFP to maintain the level of service, even if health care costs rise and the eligibility pool grows. Statutory and regulatory language regarding the state's maintenance of effort varies by service. Part H, for example,

appears to contain "maintenance of effort" language as a condition of participation under Part H.

States already using state funds to provide EI services are well advised to seek Medicaid participation; the resulting FFP may stretch state dollars, as demonstrated in the following example. Assume that a state spends \$1 million annually on EI services and has a 50% FFP for the Medicaid program. If 35% of the children served in EI by state funds are Medicaid eligible and 35% of the state's EI dollars are spent on these children, then participation in the Medicaid program will yield that state \$175,000 in FFP reimbursements ($\$1 \text{ million state expenditure} \times 35\% \text{ children eligible} \times 50\% \text{ FFP} = \$175,000$). This permits a 17.5% growth in service expenditures without additional state funds.

In Massachusetts in 1984, the year before mandated Medicaid participation in financing EI services, 2,487 children were served with a base state appropriation of about \$5.25 million. The total cost of living increase in the base over the next five years (4 percent annual increase) was \$1.19 million. In 1989, about \$3.4 million in Medicaid funds were expended for EI, of which about 50%, or \$1.7 million, was the state match. In summary, from 1984 to 1989, an additional \$2.89 million ($\$1.19 + \$1.7$) was expended by the state. This total was now used to serve 7,066 children. Thus, in a five year period, Massachusetts expanded services by 184% $\{(7,066 - 2,487) / 2,487\}$ while increasing state expenditures by only 55% ($2.89 / 5.25$).

Administrative Considerations

FFP requires "matching" state funds. For states not now delivering EI services, this match must come from a new state appropriation. The

issue for administrators in those states will be the determination of which agency receives this new appropriation, the Lead Agency or the Medicaid agency.

In Massachusetts, the appropriation for the Medicaid match goes directly to the Medicaid agency, not the Lead Agency. However, DPH, the Lead Agency, is easily able to carry out the lead agency responsibility for the administration of all EI funds because DPH has the legal authority, under state statute, to regulate these services. Through this mechanism, DPH has reached agreement with the state Medicaid agency whereby DPH has the authority and responsibility of certifying EI providers. Simply put, Medicaid will not pay a provider of EI services unless DPH has certified that the provider is meeting DPH standards for those services.

The issue of the match may cause more interagency conflict in states which already do provide some services. These states have the opportunity to expand services through Medicaid participation but some agency must provide the match. If the state's Medicaid agency is not the Part H Lead Agency, then the former has no incentive to do so. The benefits to the Lead Agency of providing the match from existing funds are clear: using existing funds as the match permits expansion of service.

Defining EI Services in the State Medicaid Plan

The Medicaid State Plan defines the services that the state proposes to provide, to whom they will be provided, and the extent and circumstances under which they will be provided. This very lengthy, complex document may be amended by the state from time to time. The

plan serves as the central contract between the state and federal government regarding the Medicaid program.

Services to be provided by the state must be included in the Medicaid State Plan. The agency within the federal government which reviews the State Plan and regulates Medicaid services is the Health Care Finance Administration (HCFA). Whether or not a state receives reimbursement for a service depends, to some extent, on interpretation by HCFA of whether or not the service was provided according to HCFA regulation.

Both the services that the federal government requires states to provide and those that are optional are defined in HCFA regulation. Since early intervention is not one of these services, the state must decide where and how to place this service in the State Plan and how to provide the service consistent with other HCFA regulation. Otherwise, there is the possibility of loss of federal funds, and, since audits may go back several years, the loss of funds could be substantial.

There are a variety of alternatives for the placement of EI services in the Medicaid State Plan. Federal options describe a variety of discrete services, including occupational therapy, physical therapy, nursing, and case management. It may be possible to gain Medicaid EI support by incorporating the service into these established options.

Massachusetts chose not to use the approach of spreading EI services among these discrete options. Each option carries with it a set of complex rules. For example, the FFP for case management differs from the FFP for other services. This approach was deemed administratively too complex and not in keeping with the

"multidisciplinary" language in Massachusetts EI enabling legislation (and later in Part H of P.L. 99-457).

Alternatively, the regulations in Massachusetts provide a "clinical services" option which may include the services of a variety of disciplines offered on an outpatient basis. Initially, Massachusetts chose to assume that EI was a part of the clinical services option. The term Early Intervention never appeared in the Medicaid State Plan. However, regulations for the clinical services option specifically require that services be provided in a clinical setting and do not permit home visits. Since more than 45 percent of EI services provided in Massachusetts are delivered in the client's home, it became clear that considering EI as a clinical service under the plan could create disallowances of some costs.

At present, Massachusetts assumes that EI is a discrete service and places it on the list with other discrete services such as occupational therapy, physical therapy, home health care, and provision of orthopedic appliances. Given the evolving statutory language regarding Congressional intent to use Title XIX for EI services, this approach is thought to be sustainable. This is, however, an unresolved issue. The states that take initiative in using Medicaid for to pay for EI will also be the ones to whom falls the thorny task of clearing the regulatory underbrush.

ISSUES REGARDING IMPLEMENTATION OF MEDICAID SUPPORT FOR EARLY INTERVENTION SERVICES

Responsibility for EI Program Development

Since Medicaid is a health insurance program, the tasks facing state Medicaid administrators are primarily fiscal and regulatory, not those of program development. In general, Medicaid personnel are responsible for designing ways to provide public financial support for service programs that have been designed by others and that are based on value systems Medicaid staff did not participate in developing. Medicaid personnel are also responsible for keeping public costs reasonable.

Therefore, regardless of how well a state has dealt with the initial considerations, it is unreasonable for lead agencies and their constituents to assume that Medicaid personnel can and will develop programs to implement the actual EI services. One cannot assume that Medicaid personnel will be familiar with early childhood developmental services and can thus "produce" a fully formed Medicaid supported system of EI services. It is quite reasonable for the state Medicaid agency to respond to requests for support of EI services with: "What is early intervention? Is it a clinical service? We do not support educational services! This does not fit into our regulations." The assumption that responses such as these are obstructionist or hostile is often unwarranted in that Medicaid personnel are being asked to do is something for which they are not responsible: program development.

The responsibility for program development under Part H lies with the Lead Agency. In a practical sense, this places the burden on Lead Agency administrators to design EI programs that move toward a good

"fit" with the Medicaid structure. Lead Agency administrators who intend to succeed in bringing Medicaid revenues into their EI systems must learn the language and values of their Medicaid colleagues before negotiations will bear fruit.

Defining Units of EI Services and Unit Rates

Unlike many other state supported health, education, and human service programs, Medicaid does not purchase entire programs or provide cost reimbursement of programs. Instead, like all other third party health insurers, Medicaid buys discrete, well defined units of service from established providers. It may be noted that since Medicaid operates like other third party health insurers in this regard, the following discussion concerning definition of service units and unit rates may also suggest strategies for accessing private third party support of EI.

The distinction between cost reimbursement of entire programs and unit purchases of discrete services may be illustrated by an example. A public health agency is concerned about the health of low birth weight newborns and determines that periodic reviews of their development is an effective preventive service. Consequently, it enters into a contract for \$100,000 with a nursing agency to provide home visiting services for a medium size community. The contract requires the nursing agency to employ nurses to periodically visit infants in their homes. The contract may or may not specify numbers of children to be served or number of visits to be made. The content of the visit may be spelled out in general terms. Duration of the visit is rarely defined. Costs, such as professional salaries, travel, space, furnishings and equipment, and support staff, are "line items" in the contract and reimbursable when

costs are incurred at levels consistent with general standards. For example, the cost of a nurse's salary may be reimbursed while the nurse is employed by contracted agency, but will not be paid for based on the number of visits that nurse makes.

This lack of definition creates flexibility that may well be in the interests of the public health agency for meeting changing needs. The precision required by Medicaid and third party payors is, however, not met. Medicaid, for example, would stipulate that a more precise definition of the service be made; e.g., the nurse's duties in the home and the length and frequency of visits would be specified. Each visit is then classified as a unit of service. The community nursing agency would be reimbursed for each unit delivered, and not for the overall costs incurred. Examples of typical units of service are a one-day hospital stay, an appendectomy in a community hospital, or a one-hour developmental group with a physical therapist for six children. The definition of a unit of service is sometimes self evident (an appendectomy), but in other cases must be derived from a close examination of the service process (developmental group).

Clearly, then, a crucial step in accessing Medicaid is the development of detailed definitions of what EI is. Massachusetts entered into a broadly based public process of setting Early Intervention Operational Standards. These standards define the client population, service provider disciplines and roles, consultants, supervision, intake, screening, evaluation and assessment, plan development, and service modes (individual and group developmental intervention, developmental monitoring, family support, and education and community consultation).

The development of the standards involved input from providers and parents. Numerous drafts were circulated and discussed at informal meetings and hearings. When the standards were adopted, Medicaid staff were involved in converting the standards into Medicaid regulations for EI.

A process to insure that the organizations providing EI service can and will continue to meet these standards must be designed and implemented. In some states, the Medicaid agency is responsible for certification or licensing of program providers or conducts program monitoring activities. In other states, some other agency, in consultation with Medicaid, has this regulatory function. While Medicaid agencies may recognize the need for certification and monitoring, the long term effort and substantial supporting resources needed may well be another barrier to the acceptance of the opportunity to support EI. In Massachusetts, state law authorizes DPH to certify and monitor Medicaid providers of EI. DPH certification is thus prerequisite to a public or private provider billing Medicaid for these services. These DPH efforts are supported through both state appropriation and federal Part H funds.

When public funds are used to purchase services, the relationship between buyer and seller almost always becomes a political process. Methods used to set the price of services, and, in this case, the price of units of service, may have some historical base, but are ultimately subject to both political factors and the rules of supply and demand. While policies for setting prices vary from state to state, efforts to set price according to some rational base is a logical starting point. Lead Agency administrators should be familiar with the strategy(ies)

employed in their state, which may include independent price setting commissions, administrative price setting, legislative price setting or pure supply and demand.

Units rates may be provider specific, in which each provider negotiates a separate rate with the purchasing agency. Class rates, in which each provider within a particular geographic area (a county or a state) is paid the same rate, are also common. Both types of rate settings may be in use in a single state. Provisions for changing rates as circumstances require must also be considered to maintain provider trust in any rate setting process.

Massachusetts, when converting from a cost reimbursement system to a unit rate system in order to access Medicaid for EI, was faced with both defining units of service and setting unit rates at the same time. Providers argued that the existing EI system contained great variation both in services delivered and in cost. Cost variations were predicted to be related to geographic location. DPH sought to determine the range of variation within EI services and the variations in cost.

As a first step, DPH consulted with providers to seek opinions on what types of services were being delivered and into what types of units these services might fall. The list resulting from these consultations contained more than thirty possible service types. DPH then conducted a detailed inventory of activities of all EI provider staff. In essence, this was a detailed time/activity study, requiring that every staff person classify activities, according to the original long list, during each fifteen minute segment of the working day for a two week period. Providers furnished DPH with detailed budget information.

A computerized analysis of activity durations and cost was conducted. The original thirty activities were reduced to seven units of service: screening, assessment, home visit, center-based individual, center-based child-focused group, center-based parent-focused group, and case management. Further cost analysis revealed that the cost of case management was uniformly 17 percent of all costs and the amount of such service was uniformly associated with all other units. Therefore, the final definition of units folded case management into the other six defined units by increasing each rate by 17 percent. Overhead and administration costs were treated in a similar manner.

The cost analysis failed to support the notion that factors such as geography, provider type, team or program size, or team composition influenced unit cost. The only significant variable was "productivity." "Productivity" was defined as the ratio of staff billable hours to total hours worked. Activities involving direct client contact may be billed to third parties, but activities such as report writing or record review usually may not. The productivity measure must be such that the ratio of billable hours to non-billable hours is high enough to recover the expense of maintaining the professional staff member. The programs that saw the fewest number of children per staff member were the most expensive.

After units were defined and costs determined, DPH made a recommendation for a state-wide class rate structure to the state's Rate Setting Commission. This structure was adopted with minor modifications. All public agencies, including Medicaid, are required to pay rates set by this Commission. It should be noted that there are 43

providers of EI services in Massachusetts, all of whom have a statutory right to appeal the rates and the rate structure; the fact that none have exercised this right in four years may speak to the inherent soundness of the original approach.

Costs of a Medicaid Plan

The tasks outlined above all require a considerable investment of time, staff, and money. Just as resources must be dedicated to development and implementation, so must resources be available for ongoing monitoring processes. Such an investment, although difficult to procure, is necessary for success. It is unlikely that the Medicaid agency will be eager to make such an investment; it has no incentive to invest resources in an effort that, if successful, will cost even more resources. It is unlikely that the details of developing and/or implementing Medicaid access can be carried out simply as additional tasks for staff already assigned to other projects. The use of Part H funds for this purpose is probably well within the intent of Congress to provide funds for the planning, development and implementation of an EI system.

In Massachusetts, the development of Early Intervention Operational Standards occupied about half of the time of a senior staff member, as well as about 20 percent of the time of a clerical person, for an entire year. The time/activity study was conducted by a consultant over a period of nine months at a cost of about \$40,000 in 1984 dollars. Clerical staff for the study was provided by the agency. Monitoring and certification is provided by four master's degree level professional staff assigned to field offices throughout the state. However, about half of

their time in devoted to program technical assistance, so that the actual FTE devoted to monitoring and certification is 2.0.

Further, Massachusetts DPH has designed and implemented a management information system that contains extensive socioeconomic, demographic, and diagnostic data on all clients served. One of the purposes of this system is to keep track of Medicaid and other third party utilization. The system cost about \$40,000 in 1983 dollars to design, with another \$15,000 invested in microcomputer equipment. Annual data entry and analysis costs are about \$50,000. This management information system was vital for implementing EI access to Medicaid; however, only an estimated 10 percent of these costs may be attributed to current Medicaid monitoring needs.

Planning for Change

Plans to introduce new revenue sources imply change; the prospect of change in any large system creates anxiety among the people in that system. Administrators intending to introduce new funding sources and related fiscal policies must anticipate and address such anxiety. Whether or not such apprehension is warranted, it is real, powerful and, if not addressed, destructive.

Concerns expressed by administrators and personnel employed by the new or existing funding sources may relate to the addition of monetary costs or the belief that burdensome new responsibilities may be required. The extent to which the coordinating administrator takes the lead in assessing actual costs and taking responsibility for necessary functions not directly related to the mission of the funding

source will determine to what extent anxiety at this stage becomes a barrier. Other specific common concerns include:

- New funding regulations rather than the needs of children will drive service;
- The new funding source will pay late and damage agency cash flow;
- Unit rate strategies will require higher levels of staff productivity and thus "burn out" already overworked staff;
- There will be more red tape and paper work.

Lead Agency administrators should not only recognize the power of these anxieties but also understand that some of these concerns may be quite true. Part H, as well as other various funding regulations, tends toward centralization and standardization. Insuring that regulations reflect "best practices" and that the development of implementation strategies fully involves parents, providers, and other agencies will mitigate the negative effects of these anxieties. Explanations regarding specific concerns raised about new practices are in order. For example, it may be clarified that unit rate systems inherently require far less paperwork than do cost reimbursement systems because the establishment of the unit rate requires a far more precise definition of the service as an initial task. Once definitions are set, each instance of service delivery does not require extensive documentation to define the service delivered in that instance.

In Massachusetts, the Medicaid agency expressed concerns about costs. More significantly, it became clear from extended discussion that the staff of the Medicaid agency assumed from the outset that the burden

of program development and monitoring would fall to them. They were concerned about this last issue in particular because experience had taught them that these tasks would have to be added to their workload. These concerns began to evaporate only after the Lead Agency for EI demonstrated their intent to take responsibility for these tasks by conducting cost studies and proposing a concrete program monitoring work plan in which Lead Agency staff were committed to these tasks.

Prior to the introduction of the unit rate system and access to Medicaid funds, the turnover among early intervention program directors in Massachusetts had been relatively low. For the two years immediately following the introduction of these strategies, turnover was very high. Since then it has stabilized at a lower level. What appears to have happened is that many directors left the system rather than change their style of supervision. It is noteworthy that by the end of this period, when overall turnover among both directors and line staff began to return to normal, more children were served. Ongoing independent evaluation indicated that program quality was either sustained or increased.

SUMMARY

Medicaid support of early intervention services is demonstrably feasible. Widespread use by states is a question only of time and no longer one of the need for enabling legislation. A key issue continues to be the availability of state matching funds. Initiative in implementing use of the Medicaid revenue stream lies with those who have the most to gain from such implementation: the Part H Lead Agency administrators.

Perceived barriers to interagency coordination between Medicaid agencies and Part H agencies may be more related to issues of values and language than to issues of willingness or turf. EI services must be defined with precision and in detail and must be shaped so as to be able to be purchased in some manifestation of a unit rate purchasing system. The resource investment required for full implementation is considerable but available through Part H.

Table 1. States' Use of Funding Sources

STATES SOURCES	A	B	C	D	E	F
Medicaid	MINOR	MINOR	MAJOR	MODERATE	MAJOR	MINOR
State or Interagency Health*	MAJOR	MODERATE	MAJOR	MODERATE	MAJOR	MAJOR
Chapter 1 (Handicapped)	MINOR	MINOR	MINOR	MODERATE	MAJOR	MINOR
State Education	MINOR	MINOR	MINOR	MAJOR	MINOR	MINOR
Private Insurance	MINOR	MINOR	MODERATE	MODERATE	MINOR	MINOR
Parent Fees	MINOR	MINOR	MODERATE	MINOR	MINOR	MINOR
Local	MINOR	MINOR	MODERATE	MAJOR	MINOR	MODERATE

* NOTE. This category includes both specific financing through a state health agency and financing through an independent interagency group in state government.

Table 2. States' Approaches to Financing

STATES APPROACHES	A	B	C	D	E	F
Unit Rate	NO	NO	NO	NO	YES	NO
Contracting Services	YES	NO	YES	YES	YES	YES
State Core Funds	YES	NO	YES	YES	YES	YES
Local Funding Initiatives	SOME	SOME	SOME	YES	NO	YES
Formal Agreements	NO	YES	NO	NO	YES	YES
Informal Agreements	YES	NO	SOME	NO	NO	NO
Local Coordination	SOME	NO	YES	SOME	NO	SOME
State Level Coordination	NO	NO	SOME	NO	SOME	SOME

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